



ILLINOIS MEDICAL ASSISTANCE PROGRAM PROVIDER BULLETIN

3/6/03

TO: Participating Optometrists

RE: Handbook for Providers of Optometric Services Update

The Handbook for Providers of Optometric Services has been revised. This handbook update includes:

- Removing coverage restrictions for participants in the Transitional Assistance Program and for adult participants in the Family and Children Assistance Program.
- Removing the rates from Appendices O-2 through O-4.
- Updates in terminology to reflect current usage.

The changes are reported on replacement pages available on the Department's website at <http://www.state.il.us/dpa/html/optometrists.htm>.

The documents are in Adobe Portable Document Format (PDF). In order to view or print the documents, you will need to have Adobe Acrobat Reader installed on your computer. Adobe Acrobat Reader is available to download FREE from the Adobe homepage at < <http://www.adobe.com> >.

If you do not have access to the Internet, or need a paper copy, printed copies are available upon written request. You need to specify a physical street address to ensure delivery. Submit your written request or fax to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Fax Number: (217) 557-8800
E-mail address is PPU@mail.idpa.state.il.us

The revised pages are dated March 2003. The affected items are designated by “=” signs to the left. This Provider Bulletin lists the pages to be removed and replaced.

INSTRUCTIONS FOR UPDATING HANDBOOK

Foreword

Remove page 12/00 IDPA O-200 (iv) and insert new page March 2003 IDPA O-200 (iv)

Basic Provisions

Remove page 12/00 IDPA O-200 (1) and insert new page March 2003 IDPA O-200 (1)

O-201 – Provider Participation

Remove page 12/00 IDPA O-201 (2) and insert new page March 2003 IDPA O-201 (2)

Remove page 12/00 IDPA O-201 (3) and insert new page March 2003 IDPA O-201 (3)

O-202 – Provider Reimbursement

Remove page 12/00 IDPA O-202 (2) and insert new page March 2003 IDPA O-202 (2)

Remove page 12/00 IDPA O-202 (4) and insert new page March 2003 IDPA O-202 (4)

Remove page 12/00 IDPA O-202 (5) and insert new page March 2003 IDPA O-202 (5)

O-204 – Noncovered Services

Remove page 12/00 IDPA O-204 (1) and insert new page March 2003 IDPA O-204 (1)

O-205 – Record Requirements

Remove page 12/00 IDPA O-205 (1) and insert new page March 2003 IDPA O-205 (1)

Appendix O-2 - Procedure Codes Billable by Opticians and Optical Companies

Remove page 12/00 IDPA Appendix O-2 (1) and insert new page March 2003 IDPA Appendix O-2 (1)

Appendix O-3 - Vision Care Procedure Codes Billable by All Optometrists

Remove page 12/00 IDPA Appendix O-3 (1) and insert new page March 2003 IDPA Appendix O-3 (1)

Remove page 12/00 IDPA Appendix O-3 (2) and insert new page March 2003 IDPA Appendix O-3 (2)

Appendix O-4 - Additional Procedure Codes Billable by TPA/DPA Certified Optometrists Only

Remove page 06/01 IDPA Appendix O-4 (1) and insert new page March 2003 IDPA Appendix O-4 (1)

Remove page 06/01 IDPA Appendix O-4 (2) and insert new page March 2003 IDPA Appendix O-4 (2)

Remove page 06/01 IDPA Appendix O-4 (3) and insert new page March 2003 IDPA Appendix O-4 (3)

Remove page 06/01 IDPA Appendix O-4 (4) and insert new page March 2003 IDPA Appendix O-4 (4)

APPENDICES

Appendix O-1	Claim Preparation And Mailing Instructions For Form DPA 1443, Provider Invoice
Appendix O-1a	Form DPA 1443, Provider Invoice
Appendix O-1b	Form DPA 2803, Optical Prescription Order
Appendix O-1c	Preparation and Mailing Instructions For Medicare/Medicaid Combination Claims
Appendix O-2	Procedure Codes Billable by Opticians And Optical Companies
Appendix O-3	Vision Care Procedure Codes Billable by All Optometrists
Appendix O-4	Additional Procedure Codes Billable by TPA/DPA Certified Optometrists Only
Appendix O-5	Preparation And Mailing Instructions For Form DPA 1409, Prior Approval Request
Appendix O-5a	Form DPA 1409, Prior Approval Request
Appendix O-6	Explanation of Information on Provider Information Sheet
Appendix O-6a	Provider Information Sheet

FOREWORD

This handbook has been prepared for the information and guidance of opticians, optical companies, optometrists and ophthalmologists who provide vision care services for participants in the Department's Medical Programs. It also provides information for opticians, optical companies and optometrists on the Department's requirements for provider participation and enrollment.

Limited guidance is contained in this handbook for the provision of medical diagnostic and therapeutic services for the eyes. Additional guidance for such medical services, whether provided by optometrists or by physicians, can be found in the Handbook for Physicians, Chapter A-200.

= This handbook can be viewed on the Department's website at

<http://www.state.il.us/dpa/handbooks.htm>

This handbook provides information regarding specific policies and procedures relating to optometric services.

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions in and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the Department's Medical Programs. The updates will be posted to the Department's website at

http://www.state.il.us/dpa/medical_programs.htm

Providers will be held responsible for compliance with all policy and procedures contained herein.

CHAPTER O-200

OPTOMETRIC SERVICES

O-200 BASIC PROVISIONS

- = For consideration for payment by the Department for optometric services, such services must be provided by an optometrist, ophthalmologist, optician or optical company enrolled for participation in the Department's Medical Programs. Services provided must be in full compliance with both the general provisions contained in the Handbook for Providers of Medical Services, Chapter 100, General Policy and Procedures (Chapter 100) and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

O-201 PROVIDER PARTICIPATION

O-201.1 PARTICIPATION REQUIREMENTS

An optometrist who holds a valid Illinois (or state of practice) license to practice optometry is eligible to be considered for enrollment to participate in the Department's Medical Programs.

- Optometrists holding non-teaching administrative or staff positions in schools or other institutions may be approved for participation in the provision of direct services if they maintain a private practice.
- Teaching optometrists who provide direct services may be approved for participation provided that salaries paid by schools or other institutions do not include a component for treatment services.

No license is required for enrollment as an optician or optical company, but the provider must be in compliance with relevant state laws in the state in which he is doing business.

Participation requirements for ophthalmologists are covered in the Handbook for Physicians. See Topic O-202.31 for instructions on obtaining a Handbook for Physicians.

The provider must be enrolled for the specific category of service for which charges are to be made.

The categories of service for which an optometrist may enroll are:

- Category 01 - Physician Services (Therapeutic Pharmaceutical Agent (TPA)/Diagnostic Pharmaceutical Agent (DPA) only)
- Category 03 - Optometric Services
- Category 45 - Optical Materials

Opticians and Optical Companies may only enroll for Category of Service 45 - Optical Materials.

Procedure: The provider must complete and submit:

- Form DPA 2243 Provider Enrollment/Application
- Form DPA 1413 Agreement for Participation
- W9 Request for Taxpayer Identification Number

These forms may be obtained from the Provider Participation Unit. E-mail requests for enrollment forms should be addressed to:

PPU@mail.idpa.state.il.us

Providers may also call the unit at (217)782-0538 or mail a request to:

Illinois Department of Public Aid

Provider Participation Unit

Post Office Box 19114

Springfield, Illinois 62794-9114

- = The forms must be completed (**printed** in ink or typewritten), signed and dated in ink by the provider, and returned to the above address. The provider should retain a copy of the forms. The date on the application will be the effective date of enrollment unless the provider requests a specific enrollment date.

O-201.2 PARTICIPATION APPROVAL

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing all data on the Department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see Appendix O-6.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to insure that all identifying information required is an exact match to that in the Department file. If any of the information is incorrect, refer to Topic O-201.4.

O-201.3 PARTICIPATION DENIAL

When participation is denied, the provider will receive written notification of the reason for denial.

- = Within ten calendar days after the date of this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten calendar days, or is received, but later withdrawn, the Department's decision shall be a final and binding administrative determination. Department rules concerning the basis for denial of participation are set out in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.

O-201.4 PROVIDER FILE MAINTENANCE

The information carried in Department files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

Provider Responsibility

- = The information contained on the Provider Information Sheet is that which is carried on Department files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found are to be corrected and the Department notified immediately.

Any time the provider effects a change that causes information on the Provider Information Sheet to become invalid, the Department is to be notified. When possible, notification should be made in advance of a change.

Procedure: The provider is to line out the incorrect or changed data, enter the correct data, date and sign the Provider Information Sheet on the line provided with an original signature. Forward the corrected Provider Information Sheet to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Failure of a provider to properly notify the Department of corrections and/or changes may cause an interruption in participation and payments.

Department Responsibility

- = When there is a change in a provider's enrollment status or a change is submitted by the provider, the Department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to all payees listed if the payee address is different from the provider address.

O-201.5 TPA/DPA CERTIFICATION

Optometrists who have received Diagnostic Pharmaceutical Agents (DPA) or Therapeutic Pharmaceutical Agents (TPA) certification from the Illinois Department of Professional Regulation may receive reimbursement for a greater range of services than non-certified optometrists. To qualify for this reimbursement, optometrists must mail or fax a copy of their license indicating the certification to the Department. They should also provide their Medicare Provider Number, if applicable. The mailing address and fax number are:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Fax number: (217) 557-8800 Attn: PPU

The Department will mail to the optometrist a copy of the Provider Information Sheet reflecting the certification status. Upon receipt of the updated Provider Information Sheet, the optometrist may begin submitting claims.

O-202 PROVIDER REIMBURSEMENT

The Department uses the Illinois Department of Corrections (DOC) for fabrication of eyeglasses. Optometrists will be reimbursed for professional services and, if appropriate, a dispensing fee for eyeglasses. Except as provided in Topic O-212.5, providers will not be reimbursed for the fabrication or sale of eyeglasses.

When billing for services or materials or both, the claim submitted for payment must include a description of the actual services provided or the materials dispensed. Any payment received from a third-party payer, a program participant or other persons incident to examination or provision of glasses must be reflected as a credit on any claim submitted to the Department bearing charges for covered services.

There are to be no arrangements to furnish more costly products such as more expensive frames or tinted lenses, etc., with the patient supplementing charges made to the Department.

O-202.1 CHARGES

Charges made to the Department are to be the provider's usual and customary charges to the general public for the services provided.

Providers may charge only for services they personally provide, or which are provided under their direct supervision in their offices by their staff, e.g., dispensing done by a technician in a provider's employ.

A provider may not charge, however, for services provided by another provider even though one may be in the employ of the other.

Providers may not charge for services provided outside their offices by anyone other than themselves.

Allowable Charges By Teaching Optometrists

Teaching optometrists who provide direct patient care may submit charges for the services provided, if the salary paid them by the school or other institution does not include a component for treatment services.

Charges are to be submitted only when the teaching optometrist seeking reimbursement has been personally involved in the services being provided. This means presence in the room performing or supervising the major phases of the services with full and immediate responsibility for all actions performed as a part of

the testing or examination. The patient's record must be documented to show these requirements have been met. All such entries must be signed and dated by the optometrist seeking reimbursement.

O-202.2 ELECTRONIC CLAIMS SUBMITTAL

Any services which do not require attachments or accompanying documentation may be billed electronically. Further information can be found in Chapter 100, Topic 112.3.

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Providers billing electronically should take special note of the requirement that Form DPA 194-M-C, Billing Certification Form, must be signed and retained by the provider for a period of three years. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form DPA 194-M-C can be found on the last page of each Remittance Advice which reports the disposition of any electronic claims. Refer to Handbook for Providers of Medical Services, Chapter 100 General Policies and Procedures, Topic 130.5 for further details.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, providers should contact the Department in the same manner as would be applicable to a paper claim. It may be necessary for providers to contact their software vendor if the Department determines that the service rejections are being caused by the submission of incorrect or invalid data.

O-202.3 CLAIM PREPARATION AND SUBMITTAL

See Chapter 100, Topic 112, for general policy and procedures regarding claim submittal. For general information on billing for Medicare covered services and submittal of claims for participants eligible for Medicare Part B, see Chapter 100, Topics 112.5 and 120.1. For specific instructions on preparation of claims for Medicare covered services, refer to Appendix O-1c.

- = The Department uses a claim imaging system for scanning paper claims. The imaging system allows more efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendix O-1 for technical guidelines to assist in preparing paper claims for processing. The Department offers a claim scannability/imaging evaluation. Please send sample claims with a request for evaluation to the following address.

Illinois Department of Public Aid
201 South Grand Avenue East
Second Floor - Data Preparation Unit
Springfield, Illinois 62763-0001
Attention: Vendor/Scanner Liaison

O-202.31 TPA/DPA Certified Optometrists

Optometrists who have supplied the Department with proof of their TPA/DPA certification may bill and be reimbursed for medically-necessary diagnostic and treatment services related to conditions of the eye. A complete list of billable services is contained in Appendices O-3 and O-4.

All of the procedures listed in Appendix O-4 should be billed using the Health Insurance Claim Form DPA 2360. For instructions on completing Form DPA 2360, see Appendix A-1 of the Department's Handbook for Physicians, Chapter A-200.

Copies of the Handbook for Physicians may be downloaded from the Department's website at <http://www.state.il.us/dpa/>

Copies may also be obtained by contacting the Provider Participation Unit at:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

E-mail: PPU@mail.idpa.state.il.us

Fax number: (217) 557-8800 Attn: PPU

For CPT codes listed in Appendix O-4 and billed by a TPA/DPA certified optometrist, an ICD-9-CM diagnosis code indicating an eye-related diagnosis is required in section D of item 24 of Form DPA 2360.

CPT codes are not to be used to bill for routine eye examinations to determine visual acuity and the refractive state of the eyes or for dispensing fees. Continue to bill these services on Form DPA 1443, Provider Invoice, as described in Topic O-202.32 below.

O-202.32 Non-TPA/DPA Certified Optometrists

Form DPA 1443, Provider Invoice, is to be used to submit charges for covered services provided by optometrists who are not TPA or DPA certified. A copy of the Form DPA 1443 and detailed instructions for completion are included in Appendices O-1 and O-1a.

All services for which charges are made are to be coded on Form DPA 1443 with specific procedure codes as described in Appendix O-3. No other procedure codes are acceptable. Reimbursement will not be made for services provided when the claim has been completed with invalid procedure codes.

O-202.33 Opticians and Optical companies

Form DPA 1443, Provider Invoice, is to be used to submit charges for covered services provided by opticians and optical companies. A copy of Form DPA 1443 and detailed instructions for completion are included in Appendices O-1 and O-1a.

All services for which charges are made are to be coded on Form DPA 1443 with specific procedure codes as described in Appendix O-2. No other procedure codes are acceptable. Reimbursement will not be made for services provided when the claim has been completed with invalid procedure codes.

O-202.34 Claims Submittal

All routine paper claims, including those with an Optical Prescription Order (OPO) form attached, are to be submitted in a pre-addressed mailing envelope provided by the Department for this purpose, Form DPA 1444, Provider Invoice Envelope. Routine claims with an OPO attached and routine claims with no OPO attached should be mailed in separate envelopes. Using the pre-addressed envelopes and separating claims as described above should insure that claim forms will be properly routed for processing.

= For a non-routine claim submittal, use Form DPA 2248, Special Handling Envelope. A non-routine claim is:

- Any claim to which Form DPA 1411, Temporary MediPlan Card, is attached.
- Any claim to which a document other than the OPO is attached.

For electronic claims submittal, see Topic O-202.2 above. Non-routine claims and claims with an OPO attached may not be electronically submitted.

O-202.4 PAYMENT

- = Payment made by the Department for allowable services will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the Department. Refer to Chapter 100, Topics 130 and 132, for payment procedures utilized by the Department and General Appendix 8 for explanations of Remittance Advice detail provided to providers.

Reimbursement for Vision Examinations

The reimbursement made for the vision examination to determine the condition of the eye includes all services provided during the examination and associated vision care services provided as a result of examination findings, such as the writing of an Optical Prescription Order (OPO).

Reimbursement for Medical Services

When an initial medical office visit and a procedure are provided for a new patient on the same day, each service may be payable at the rate described earlier in this Topic. On subsequent medical visits when a procedure is performed the same day, the provider may bill both, but the Department's total payment will be capped. In calculating the cap, the Department compares the maximum rate payable for each service billed and selects the highest amount payable.

Reimbursement for Contact Lenses

Except lenses for aphakic children under the age of three, coverage of contact lenses is subject to prior approval. Refer to Topic O-212.2.

The reimbursement made for contact lens services includes the carrying case, appropriate solutions and equipment, verification and inspection of lenses, all studies made including time spent to advise the patient in care and in use of the lenses (subsequent office visits and consultations to achieve maximum wearing time) and any modifications of lenses during the adaptation period.

The payment for contact lenses for aphakic children will be based upon the acquisition cost to the provider. The acquisition cost is defined as the actual amount the supplying provider must pay to acquire the contact lens(s), taking into account any discounts, rebates or bonuses and including all freight, postage, delivery and demurrage. Patient records should document acquisition costs.

O-204 NON-COVERED SERVICES

Services for which medical necessity is not clearly established are not covered in the Department's Medical Programs. Also see Chapter 100, Topic 104, for a list of services and supplies for which payment will not be made.

In addition, the following optometric services are excluded from coverage in the Department's Medical Programs and payment will not be made for the provision of these services:

- routine screenings
- routine periodic exams in the absence of an identified problem
- examination required for the determination of disability or incapacity. (Local Department of Human Services offices may request that such examinations be provided with payment authorized from nonmedical funds. Optometrists are to follow specific billing instructions given when such a request is made.)
- Services provided in federal or state institutions

O-205 RECORD REQUIREMENTS

- = The Department regards the maintenance of adequate records essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits. Refer to Chapter 100, Topic 110 for record requirements applicable to all providers.

Providers must maintain an office record for each patient. In group practices, partnerships, and other shared practices, one record is to be kept with chronological entries by the individual optometrist, physician or optician rendering services.

The record maintained by the provider is to include the essential details of the patient's condition and of each service or material provided. Any services provided a patient by the provider outside the provider's office are to be documented in the medical record maintained in the provider's office. All entries must include the date and must be legible and in English. Records which are unsuitable because of illegibility or because they are written in a language other than English may result in sanctions if an audit is conducted.

For patients who are in a nursing facility, the primary medical record indicating the patient's condition and treatment and services ordered and provided during the period of institutionalization may be maintained as a part of the facility chart; however, an abstract of the facility record, including diagnosis, treatment program, dates and times services were provided, is to be maintained by the provider as an office record to show continuity of care.

Opticians and optical companies must maintain records adequate to document items dispensed and services provided, and to document that eyeglasses and other eye care materials are dispensed only in accordance with a prescription written by a physician or an optometrist.

The Department and its professional advisors regard the preparation and maintenance of adequate medical records as essential for the delivery of quality medical care. In addition, providers should be aware that medical records are a key document for post payment audits.

In the absence of proper and complete medical records, no payment will be made and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

**APPENDIX O-2
PROCEDURE CODES BILLABLE BY OPTICIANS
AND OPTICAL COMPANIES**

PROCEDURE CODE	DESCRIPTION	PRIOR APPROVAL REQUIRED
X1015	Dispensing Fee	
X1016	Service Fee	
V2500	Hard Contact Lens (each)	Yes
V2510	Gas Permeable Contact Lens (each)	Yes
V2520	Soft Contact Lens, Hydrophylic, Spherical (each)	Yes
X2500	Hard Contact Lens (pair)	Yes
X2510	Gas Permeable Contact Lens (pair)	Yes
X2520	Soft Contact Lens, Hydrophylic, Spherical (pair)	Yes
X1047	Prism up to 4 Degrees	
X1048	Prism 4 Degrees and Above	
X1021	Nose Pad Replacement	
X1024	Temple Replacement (each)	
X1025	Temple Replacement (pair)	
X1026	Frame Front	
X1028	Frame Repair, Service Only	
V2600	Hand Held Low Vision Aid	Yes
V2629	Custom Artificial Eye	Yes
V2799	Service Not Listed	Yes

APPENDIX O-3**VISION CARE PROCEDURE CODES
BILLABLE BY ALL OPTOMETRISTS**

PROCEDURE CODE	BRIEF DESCRIPTION	PRIOR APPROVAL REQUIRED
X1010	Examination, Office	
X1011	Examination, Other Location	
X1015	Dispensing Fee	
X1016	Service Fee	
V2500	Hard Contact Lens (each)	Yes
V2510	Gas Permeable Contact Lens (each)	Yes
V2520	Soft Contact Lens, Hydrophylic, Spherical (each)	Yes
X2500	Hard Contact Lens (pair)	Yes
X2510	Gas Permeable Contact Lens (pair)	Yes
X2520	Soft Contact Lens, Hydrophylic, Spherical (pair)	Yes
X1044	Contact Lens Service (each)	Yes
X1045	Contact Lens Service (pair)	Yes
W7257	Aphakic Infant Contact, Single	Yes
W7258	Aphakic Infant Contact, Pair	Yes
W7259	Aphakic Contact Lens Service, Single	Yes
W7260	Aphakic Contact Lens Service, Pair	Yes
X1047	Prism up to 4 Degrees	
X1048	Prism 4 Degrees and Above	
X1021	Nose Pad Replacement	
X1024	Temple Replacement (each)	

PROCEDURE CODE	BRIEF DESCRIPTION	PRIOR APPROVAL REQUIRED
X1025	Temple Replacement (pair)	
X1026	Frame Front	
X1028	Frame Repair, Service Only	
V2600	Hand Held Low Vision Aid	Yes
V2629	Custom Artificial Eye	Yes
V2799	Service Not Listed	Yes

APPENDIX O-4

ADDITIONAL PROCEDURE CODES BILLABLE BY TPA/DPA CERTIFIED OPTOMETRISTS ONLY

CODES BILLABLE BY BOTH DPA AND TPA CERTIFIED OPTOMETRISTS

In addition to the codes listed in Appendix O-3, the following CPT codes are billable by both DPA and TPA certified optometrists. Note: No prior approval is required for these codes.

PROCEDURE CODE	BRIEF DESCRIPTION
76511	Ophthalmic Ultrasound, A-scan Only
76512	Ophthalmic Ultrasound, Contact B-scan
76516	Ophthalmic Biometry by Ultrasound, A-scan
76519	Ophthalmic Biometry with Intraocular Lens Calculation
92002	Ophthalmological exam, intermediate, new patient
92004	Ophthalmological exam, comprehensive, new patient
92012	Ophthalmological exam, intermediate, established patient
92014	Ophthalmological exam, comprehensive, established patient
92020	Gonioscopy
92060	Sensorimotor exam w/measures of ocular deviation
92081	Visual field exam with interpretation
92082	Visual Field Exam, Intermediate
92083	Visual Field Exam, Extended
92100	Serial tonometry w/measures of intraocular pressure
92225	Ophthalmoscopy, Extended, with Retinal Drawing, New
92226	Ophthalmoscopy, Extended, Subsequent
92250	Ophthalmoscopy, Fundus Photography
99201	E/M Office visit, new patient

PROCEDURE CODE	BRIEF DESCRIPTION
99202	E/M Office visit, new patient
99203	E/M Office visit, new patient
99211	E/M Office visit, established patient
99212	E/M Office visit, established patient
99213	E/M Office visit, established patient
99301	E/M Nursing home visit, comprehensive exam
99302	E/M Nursing home visit, comprehensive exam
99311	E/M Nursing home visit, problem focused exam
99312	E/M Nursing home visit, problem focused exam
99321	E/M Domiciliary visit, problem focused, new patient
99322	E/M Domiciliary visit, expanded focused, new patient
99331	E/M Domiciliary visit, focused, established patient
99332	E/M Domiciliary visit, expanded, established patient
99347	E/M Home visit, focused exam, established patient
99348	E/M Home visit, expanded exam, established patient

Detailed code definitions can be found in the Current Procedural Terminology (CPT) published by the American Medical Association.

CODES BILLABLE BY TPA CERTIFIED OPTOMETRISTS ONLY

In addition to the codes listed in Appendix O-3, the following CPT codes are billable by TPA certified optometrists:

PROCEDURE CODE	BRIEF DESCRIPTION
65205	Remove foreign body, conjunctival superficial
65220	Remove foreign body, corneal, without slit lamp

PROCEDURE CODE	BRIEF DESCRIPTION
65222	Remove foreign body, corneal, with slit lamp
65430	Scraping of cornea, diagnostic
67820	Correction of trichiasis, epilation, by forceps only
68040	Expression of conjunctival follicles
68761	Closure of lacrimal punctum, by plug, each
92270	Electro-oculography
92285	External ocular photography
92286	Anterior segment photography with microscopy